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Original Lectures.

LECTURES
ON THE
DIAGNOSIS OF DISEASES OF THE HEART.

DELIVERED AT THE
BELLEVUE HOSPITAL MEDICAL COLLEGE DURING THE PRELIMINARY TERM.
SESSION 1862-63.

BY AUSTIN FLINT, M.D.
PROFESSOR OF THE PRINCIPLES AND PRACTICE OF MEDICINE.

LECTURE III.

Of the Mechanism of the Production of the Second Sound of the Heart.—Of the Valvular Element and the Element of Impulsion composing the First Sound of the Heart.—The Proof of the Existence of these two Elements afforded by Auscultation of the Healthy Chest.—Representation of the Characters of the Two Sounds of the Heart by Whispered Words.—The different Blood-Currents, Normal and Abnormal, through the Mitral and Aortic Orifices: viz. the Mitral Direct, the Mitral Regurgitant, the Aortic Direct, and the Aortic Regurgitant.—The Relations of these different Currents to the Heart-Sounds.—General Account of Valvular Lesions.—Endocardial Murmurs.—Murmurs produced by the Blood-Currents become the Signs of Valvular Lesions.—Different Characters of Murmurs, viz. Soft, Rough, Musical.—Four Murmurs corresponding to the Four Blood-Currents, distinguished by the same Names, and having the same Relations to the Sounds of the Heart.

GENTLEMEN:—As introductory to the consideration of the diagnosis of valvular lesions, I gave an account in my last lecture of the normal sounds of the heart. I described the relative characters of the first and second sound as heard on auscultation over the apex of the heart, and the rhythmical succession of the two sounds. Let me now briefly state the mechanism by which the sounds are produced. The second sound, as all are now agreed, is due to the sudden expansion of the segments forming the aortic and pulmonic valves; the force causing the expansion of these segments is derived from the recoil of the arterial coats, occurring after the arteries have been distended by the blood propelled into them by the systolic contraction of the ventricles. Owing to the elasticity of their coats, the arteries recoil upon the blood which they contain immediately the propelling force of the ventricles ceases, and this recoil would drive a portion of the blood back into the ventricles, were it not that the movement of the blood in a retrograde direction expands, with quickness and force, the valvular segments which close the arterial orifices, and regurgitation is thus prevented. This mechanism is important to be recollected with reference to an understanding of the physical signs of disease. The sudden forcible expansion of the valvular segments, as just described, gives rise to the second sound of the heart. The first sound is less simple. It is a compound sound, and all are not agreed concerning the mechanism of its production. Without entering into a discussion of the matter, I shall give you my opinion, viz. that this sound is composed of two elements: one element being a sound produced by sudden and strong tension of the auriculo-ventricular valves (mitral and tricuspid) when the ventricles contract, and the other element being a sound produced by the movements of the apex of the heart against the thoracic walls during the ventricular systole. For the convenience of reference I am accustomed to call the first the valvular element, and the second, the element of impulsion. This subdivision of the first sound into these two elements is involved in the understanding of certain of the signs of disease.

Let me dwell upon this point sufficiently to tell you how the fact of the first sound being composed of the two elements just named is susceptible of proof. The characters of the first sound, as compared with those of the second sound, which I described in my last lecture, are the characters belonging to this sound when heard over the apex of the heart. If, after listening to the first sound over the apex, you remove the stethoscope at a certain distance from the heart, you will find that most of the distinctive characters of this sound are lost: it is no longer louder and longer than the second sound, and the booming quality has disappeared. It is now short and valvular like the second sound, being less intense and still lower in pitch. What has occasioned this difference? The element of impulsion is eliminated, and the valvular element only remains. This is the explanation. The element of impulsion is propagated but little beyond the heart; the valvular element is propagated further; consequently, at a certain distance from the border of the heart, we eliminate the element of impulsion, and have only the valvular element. It is the element of impulsion which gives to the first sound, over the apex, its intensity, its length, and its booming quality. The valvular element of the first sound is less intense than the second sound, has the same valvular quality, is as short, and is lower in pitch. These points you can easily verify for yourselves, and I hope you will do so. Another mode in which you may eliminate the element of impulsion from the first sound, is to place between the pectoral extremity of the stethoscope and the chest several thicknesses of soft cloth. By this means you prevent the transmission of the element of impulsion, but not of the valvular element. This experiment you can easily make.

The correctness of this explanation of the mechanism of the first sound of the heart is confirmed by the effects of disease upon this sound. These effects constitute physical signs of disease to which I shall hereafter refer. With regard to the movements of the heart giving rise to the element of impulsion, let me say that they consist of the locomotion of the apex from left to right, the rotation of the organ in the same direction, and the elongation of the organ—all occurring during the ventricular systole. When I mention the elongation of the heart during the systole, I should add that this is at variance with some physiological writers, who state that the organ diminishes in length; but that the heart really elongates will be demonstrated to you to-morrow by the Professor of Physiology, who will show this, together with other points connected with the movements of the organ, by exposing it to view while in action in an animal poisoned by woorara.

Reverting to the rhythm and distinctive characters of the heart-sounds, these may be represented by certain words pronounced in a whisper. Bouillaud, who first proposed this plan, employed the words *tic-tac*. These words, however, do not represent the differences of pitch, quality, and length, between the two sounds, so well as other words which have been suggested. The words *lub-dup*, proposed by Dr. Williams, or *too-to*, proposed by Dr. Hughes, answer very well. The words used by Bouillaud answer equally well if they are simply reversed, viz. *tac-tic*; pronouncing these words in a whisper you have the relative characters of the first and second sounds very well represented. Representing the two sounds as heard at the apex, the stress of the voice should fall on the *tac*; the first sound in this situation, being the louder, is said to be accentuated. But to represent the relative intensity of the two sounds at the base of the heart, the stress should fall on the *tic*; the second sound in this situation being the accentuated sound.

As a further preliminary to the consideration of the diagnosis of valvular lesions, the different blood-currents through the orifices of the heart in health and disease, and their relations, severally, to the heart-sounds, must be clearly understood and familiar. I have already said that valvular lesions in the great majority of cases are limited to the left side of the heart. In considering the blood-currents, we will direct our attention to the left ventricle and auricle;

but the existence of corresponding currents on the right side of the heart will be sufficiently intelligible. There are two currents pertaining to health on the left side, viz. the *mitral direct* and the *aortic direct current*. We call these *direct* currents because the flow of blood through the orifices named is in its direct, normal course. The *mitral direct current* is from the left auricle into the left ventricle through the auriculo-ventricular or mitral orifice. Now, when does this current take place as regards the heart-sounds? It takes place when the auricle contracts, and the auricle contracts just before the contraction of the ventricle. The ventricular and the auricular contractions follow in quick succession, so that the two contractions succeed each other with scarcely an appreciable interval between them. This will be demonstrated in the physiological lecture to-morrow, when the heart in action will be exhibited to you. The first sound of the heart is due to the contraction of the ventricles; hence, the mitral direct current of blood must take place just before the first sound; it is pre-systolic, and there is no interval between its occurrence and the first sound.

The *aortic direct current* is from the left ventricle into the aorta. When does this current take place as regards the heart-sounds? It takes place when the ventricle contracts. And, since it is the contraction of the ventricles which causes the first sound of the heart, the current must take place with the first sound.

So much for the two direct currents. Corresponding currents on the right side of the heart should be called the *Tricuspid direct* and the *Pulmonic direct current*. The two remaining currents on the left side are abnormal, and they are distinguished as *regurgitant* currents. These currents only exist when certain valvular lesions are present; and this fact leads me to give a general account of lesions affecting the valves and orifices of the heart.

Valvular lesions are varied in their character. I cannot consider them fully in this connexion. They are due to atrophy of the valves, rupture, atheromatous and calcareous degeneration, warty growths, etc. On the table before me are several specimens. Suffice it to say, that the varied lesions may produce, *First*, contraction of the mitral or aortic orifice. Lesions producing this effect are called obstructive lesions; they obstruct the direct blood-currents. *Second*, they may impair the aortic valvular segments or the mitral valvular curtains, and render them to a greater or less extent inadequate to protect the orifices. The valves are then said to be insufficient or incompetent, and the orifices are said to be patescent. Consequently, regurgitation ensues, and then we have regurgitant blood-currents. If the mitral valvular curtains are damaged, we have the *mitral regurgitant current*. This abnormal current is from the ventricle to the auricle. When does it take place as regards the heart-sounds? The current is produced by the contraction of the ventricle; and, since the contraction of the ventricle causes the first sound of the heart, this current, of course, is with that sound.

If, on the other hand, the aortic valvular segments are rendered incompetent, we have the *aortic regurgitant current*. This current is from the aorta into the left ventricle. When does it take place as regards the heart-sounds? The current is due to the recoil of the arterial coats; and as we have seen that it is this recoil which causes the second sound of the heart, this current is with that souud.

Third, Valvular lesions may exist without involving either obstruction or regurgitation; they may simply present a roughened surface to the blood-currents in their direct course. We shall see hereafter that under these circumstances they give rise to physical signs. It may seem to you, gentlemen, that I am needlessly minute and tedious in these preliminaries to the consideration of the diagnosis of valvular lesions. But I assure you I am not so. Without a clear apprehension of, and familiarity with the blood-currents just named, and their relations to the heart-sounds, the signs on which the diagnosis of valvular lesions is based, cannot be made intelligible; and with this preparatory acquaintance with the blood-currents, the diagnostic signs of valvular lesions are at once easily understood. Let me, therefore, recapitulate the four currents; and I would urge you to repeat them sufficiently to render them perfectly familiar. Arranging them now into two classes, viz. the mitral and aortic, we have *First*, the mitral direct and the mitral regurgitant current; *Second*, the aortic direct and the aortic regurgitant current. The mitral direct current, produced by the contraction of the auricle, is pre-systolic, that is, it occurs just before the first sound of the heart. The mitral regurgitant current, produced by the contraction of the ventricle, occurs with the first sound of the heart. The aortic direct current, produced by the contraction of the ventricle, occurs with the first sound of the heart. The aortic regurgitant current, produced by the recoil of the arterial coats, occurs with the second sound of the heart. Adopting another classification, we may arrange the different currents into, *first*, those occurring with the first sound of the heart, and *second*, those occurring with the second or before the first sound; the former we may call the *systolic*, and the latter the *diastolic* currents. The systolic are the mitral regurgitant and the aortic direct current. The diastolic are the mitral direct and aortic regurgitant current.

I come now to consider signs of disease incidental to the blood-currents just considered. In health, as we have seen, we have only the direct currents, and these, owing to the smooth and polished membrane which lines the valves and orifices of the heart, occasion no sound. We have only, in health, the two heart-sounds which have been considered. If, however, the orifices through which the currents flow be contracted by obstructive lesions; if the valves are rendered incompetent by lesions so that regurgitant currents take place, or even if the endocardial membrane be roughened by calcareous deposits, vegetations, etc., adventitious or abnormal sounds are produced. These abnormal or adventitious sounds are called *murmurs*. Here is a conventional use of terms which is to be borne in mind. The two sounds of the heart, either preserving their normal characters or modified by disease, are known as the heart-sounds; but all sounds which are originated by disease—adventitious—are distinguished as cardiac murmurs. The *murmurs* produced by the blood-currents within the heart are further distinguished as *endocardial murmurs*, and murmurs without the heart, that is, on the heart's surface, are distinguished as *exocardial*, or, sometimes, *pericardial* murmurs.

The murmurs produced by the blood currents, or the endocardial murmurs, differ as regards intensity, pitch, and quality. They may be more or less intense, varying from such a degree of fulness that they are with difficulty appreciated, to such a degree of loudness that they may be heard at a distance from the chest. They may be high or low in pitch. In quality they are said to be soft, rough, and musical. Generally they are soft, and resemble the sound produced by the air coming from a pair of bellows; and then, they are said to be bellows or blowing murmurs. Sometimes the quality of sound is expressed by such terms as rasping, filing, grating, croaking, and then the murmurs are said to be rough. In some rare instances (I happen to have an example now in my hospital wards) they have a musical intonation. I may remark here that the intensity, pitch, and quality of the murmurs have not, in general, much pathological or diagnostic significance. Their value in the discrimination of valvular lesions depends chiefly on other points, and the first point is always to determine by which of the four blood-currents is a particular murmur produced.

Continuing to limit our attention to the left side of the heart, each of the four blood-currents which we have considered, may give rise to a murmur, either soft, or rough, or musical. There are, therefore, four cardiac murmurs: two produced at the mitral and two at the aortic orifice. These murmurs are distinguished by the same names as the blood-currents. We have a mitral direct and a mitral re-

gurgitant, an aortic direct and an aortic regurgitant murmur. These murmurs denote the existence and the situation of valvular lesions. Whenever we find an endocardial murmur we desire, in the first place, to determine which one of these four murmurs it is. How do we determine this? By ascertaining, in the first place, its relation to the heart-sounds. The relations of the several murmurs to the two sounds of the heart are, of course, the same as the relations of the blood-currents. Consequently, a mitral direct murmur will immediately precede the first sound, and the mitral regurgitant murmur will accompany and follow that sound; the aortic direct murmur will also accompany and follow the first sound, and the aortic regurgitant murmur will accompany and follow the second sound of the heart.

It remains to point out additional means of discriminating these four murmurs; to explain the mode of determining when two or more of them are present, as is not unfrequently the case, and to consider their diagnostic significance and value. These points I must reserve for my next lecture.

Original Communications.

REMARKS ON ALBUMINURIA,

MADE BEFORE THE NEW YORK ACADEMY OF MEDICINE.

By A. CLARK, M.D.,

PROF. OF PRACTICE AND PATHOLOGY.

(*Continued from* p. 187.)

We now turn to the fatty degeneration as it is called This term embraces the deposit of oil globules in three different parts of the kidney structures; within the cells of the epithelial lining; within the tubes when the epithelium has been more or less removed; and in the midst of the fibrous matrix or intertubular structure. The deposit is more frequently seen in the epithelial cells than in the empty tubes; but in all these forms it is an accident of Bright's disease frequently met with. Mark, an *accident.* And I wish to say again to those who are accustomed to speak of *fatty kidney* as one of the forms of that affection, that though fatty deposit may be a marked feature of this or that specimen, it does not characterize any variety of the disease to the exclusion of other lesions, and has no claim to be the basis of a classification. At least in these thirty cases, though it occurred very often, and in its various forms, there was not a case in which it was not attended by other grave changes; and in a much larger range of cases, I cannot remember an instance in which it occurred alone. Its presence or absence cannot be known during life by any symptom, or inferred from the habits or condition of the patient with any degree of certainty, except from the fact of finding or not finding fatty cells or fatty casts in the urine. It is true, that among the lesions of the large white kidney, oil globules in greater or less quantity are almost always to be found, and that we may often recognise this kidney before death. So far we can go. But this is in no proper sense *the* fatty kidney.

The infiltration of oil into the cells of the epithelium varies in degree from a globule or two, to the greatest capacity and distension of the cell. The globules are usually small and often numerous, as seen on cards No. 7, 9, and 14, though sometimes they are of such size that one to six of them will not only fill but greatly distend a cell, as on No. 17. Sometimes a few only of the cells in the different tubes contain the oil, the others presenting a healthy appearance; and again, the deposit will be found more or less abundant in one-half, or two-thirds, or indeed in almost all the cells throughout the organ. When the fatty deposit in the cells is at all considerable, the attachment of these cells to the basement membrane is easily broken up, and slight manipulations empty the tubes, while the fatty cells are seen floating in the menstruum by which the piece is surrounded. The oil-laden epithelium is not only discharged in this way after death, but there is reason to suppose that it is easily cast off during life, for we occasionally find great numbers of these fatty cells in the urine; and in our microscopic examinations we sometimes find tubes entirely destitute of epithelium of any kind, and filled with oil globules, large and small. This oily exudation must have occurred before death, and the epithelium must have been cast off before it could have occurred. Examples of these oil-filled tubes are seen on the large sheets, on a card No. 16, and on that marked "Beaumont's kidney." In none of these instances was there any considerable amount of oil in the intertubular spaces to favor the idea of post-mortem infiltration. It is to be remarked, that in these tubes there appears to be no more power to reproduce the epithelium than in those that have been denuded by granular degeneration. It is barely possible that the oil within the otherwise empty tubes may come from the bursting of fat-laden cells; but there is no evidence of it in the discovery of here and there a less heavily laden cell, or of the debris or fragments of cells. Besides this, there is no reason for supposing that the fatty cells are destroyed as the granular cells are; but it would seem that when they are filled to a certain degree, they fall off and are carried away with the cell-walls unbroken, Thus we have the deposit of oil globules in the cells, and in the uriniferous tubes when deprived of epithelium.

We often see it also infiltrated into the fibrous matrix. Granular matter such as is seen within the tubes is not found here. There is a very fine nebular deposit often in the midst of the fibres and on the malpighian bodies, the nature of which I have not investigated. Occasionally, the fibres themselves appear granular, as if granules produced from the plasma could not be marshalled into their places to form compact tissue, or as if protein granules were produced in needless profusion, and could undergo no further transformation. These granules are larger than those which result from the breaking up of the epithelial cells, having more resemblance to fat globules, with which they are often mingled. The fibrous matrix itself sometimes breaks down, leaving a granular debris mingled with oil globules. It is claimed that this change is a conversion of a protein or fibrous tissue into oil or fat. This may be so, but it seems to me more in accordance with known facts to suppose that while the fibrous material is undergoing disintegration and removal, there is a deposit of oily matter, in the same manner as when the liver, or the cells or tubes of the kidney, become fatty. This oil is probably a contribution from the dissolved fat of the circulating blood. The intertubular fat is usually deposited in small globules, though sometimes the globules attain considerable size. It is sometimes seen in thousands of shining grains on the outside of the uriniferous tubes, and not in the fibrous matrix proper, though far more commonly it is diffused pretty regularly through the latter. The illustration of this outside tubular deposit may be seen on card No. 8, and the more general diffusion of it on No. 12. This intertubular oil is sometimes deposited in circumscribed spots, and not distributed evenly through the matrix. When this is the case there are usually evidences of disorganization, such as the absence of tubes, and a granular condition of the fibrous tissue, at these particular spots. Such a spot has a grey or white opaque appearance, and when the spots are numerous, we get one of the varieties of grey mottled or spotted kidney. It will soon appear that this excess of oil globules, in one or other, or in all the forms here described, is one of the causes of the white, yellowish, or grey color which the large kidney is so apt to assume. The granular degeneration just described is another of the causes of this change of color.

The fatty and granular changes often concur in the same kidney, as I have already stated, and when combined each contributes to the same result. I exhibit here some illustrations of this concurrence. Cards Nos. 10, 11, and 15, show cells which are undergoing the granular disintegra-

tion, and contain at the same time many small oil globules. No. 9 exhibits groups of cells in different stages of the granular degeneration, and among them only here and there a small globule, also a group of cells from another part of the same kidney, that are heavily loaded with oil; —while Beaumont's kidney and No. 16 show us tubes deprived of epithelium, and loaded with granules and oil globules mingled in varying proportions. Either of these two lesions may occur separately, or they may co-exist in the same organ, both of them varying in degree almost infinitely.

The malpighian bodies, in the large proportion of cases, are found to have undergone little or no change. In rare instances, they will be very conspicuous in the microscopic field, on account of the bright blood color which they retain. One aspect of this condition has been already spoken of. If kidneys could be seen during life, this red color would doubtless be found to be normal; but when, after death, after the large vessels have been cut in removing the organ from the body, and the smaller ones in getting a portion for microscopic examination, the blood still fills the malpighian tufts, it is received as evidence of ante-mortem congestion, and a congestion affecting these bodies disproportionately, perhaps. I do not know that this state has any other significance. When seen, it does not characterize any particular stage of disease, though most frequently met with in the earlier periods, and rarely if ever in the contracted kidney. In such cases, the urine of the last twenty-four hours, or last days of life, is frequently scanty, high colored, and contains blood. The last marked case which I have met with was in a young man who had had paraplegia for two years, and Bright's disease for several months. The kidneys weighed between six and seven ounces each, and contained an excess of fibres and some cysts.

The malpighian bodies are also subject to important alterations in the fibrous or contracted kidney. The capsule or investing membrane, usually thin, delicate, and hyaline, often becomes thickened and fibrous, and greatly contracted. When this happens, the fibres which have been added are usually distinctly visible by the microscope, giving to the membrane an aspect very different from that which it has when natural. The body is by this means contracted, sometimes even to a quarter of its proper dimensions. With this contraction there is a dwarfing of the inclosed tufts, and not unfrequently a complete absorption of them; and it is noticeable often that the tufts are shrunken in a greater degree than the capsule is contracted, so as to leave an unoccupied space within the diminished capsular cavity. Thus, many of these important bodies are, in some instances partially, in others wholly destroyed; and this it appears to me is effected by the contraction of new, or at least abnormal fibrous tissue, in this instance deposited on a tissue in which naturally fibres cannot be seen. In some kidneys a very considerable proportion of these bodies have undergone these changes, but never all of them.

In the same variety of this disease, the uriniferous tubes are often found to be seriously implicated. Their size is seen to be diminished through large portions of the kidney. In certain limited portions they are occasionally entirely destroyed. When the tubes have disappeared, their places seem to be taken by granular fibres, the pseudo-fibrous debris of the tubes, rather coarse granules and oil globules. These changes seem to be most easily explained by supposing them to be the effect of pressure produced by the contraction of an unnatural amount of fibrous tissue.

Serous cysts, often of a size to be appreciated by the eye alone, often microscopic, are very common in the contracted kidney. Numbers of them may be seen in the drawings of the small and medium-sized kidneys, now in the hands of the Fellows. Those that are visible to the naked eye, vary in these specimens from the size of a pin's head to that of a bean. They are distributed everywhere through the secreting portion of the organ, but those that principally attract attention, though formed in the cortical layer, have pushed out and become prominent on the surface. They consist of a semi-transparent capsule or cell, and nearly transparent watery contents. The size to which they can attain, or the number which can be formed in any particular organ, is almost indefinite, but those here represented are not very large or very numerous. They may occur in kidneys not known to be fibrous, or in any other manner diseased than that they are invaded by these cysts. The origin of these bodies has been the subject of much speculation, and of some research. It is claimed that they are produced by a serous infiltration into the inverted portions of the uriniferous tubes which are supposed to be reflected over the malpighian bodies to form their capsules. It would be near the truth, therefore, in this view, to call a serous cyst, a dropsy of one of the malpighian bodies. Another theory is, that they are formed by the extraordinary development of some of the natural cells of the organ; and as all the natural cells are within the tubes, except the fibre-cells, which have never been thought susceptible of this transformation, this hypothesis implies that the cyst is at first intratubular. But the opinion which has the endorsement of Dr. George Johnson, is the only one which I need stop to consider. In his view these cysts are formed out of the uriniferous tubes after the epithelium has been cast off. He gives a figure (p. 218) of such a tube undergoing the change into cysts, "much dilated, and bulging in the intervals of the fibrous rings, by which it has, in parts, been constricted." The idea seems to be that the fibrous matrix, or portions of it, contract irregularly around the tube and cut it into sections, and that in each of these sections the tube becomes closed so as to form a cell or cyst, thus making a series of cysts, which gradually enlarge till they are of a size to be examined by the naked eye. "A careful examination," he says, "will always detect in immediate contact with the cyst-like appearances, unequivocal portions of the elongated tube having the same structure and contents as the other parts, and evidently identical and continuous with them, the continuity only being concealed by the fibrous tissue in which they are packed." It is now many years since I explained my own views of the origin of these cysts to the Pathological Society. Before I was acquainted with the opinion of Rokitansky or Prof. Paget, and I believe before their observations were published, I had become convinced that they begin in independent germs, that they are recognisable as cells while they are yet small, smaller than the uriniferous tubes, and that they can be seen of increasing size, of every possible diameter, up to those that are large enough to be appreciated by the naked eye. They are wholly intertubular, and nothing that I have ever seen would allow me to admit Mr. Simon's theory that they are originally epithelial cells which have escaped into the matrix by the bursting of the tubes. They appear to my eye to have the same origin that cysts have, around and behind an indurated or a cancerous breast; in the neck, when not connected with the thyroid gland; in the bones, and in the muscles. I call attention particularly to the cysts which occur among the fibres of muscles, and also to those which are found in the adventitious fibrous layer which is formed in chronic dysentery under the peritoneal covering of the large intestines, as they resemble very strikingly the serous cysts of the kidney. A drawing that I here exhibit will give an idea of their appearance among the multiplied fibres of the intestine. But for the absence of tubes in the tissue, they might be mistaken for kidney cysts. They are, however, more markedly oval, and their contents are more granular than would usually be found in that organ. Cysts of this kind, as well as those which occur in fibrous and other tumors, can hardly be accounted for on the supposition that they are transformations of any of the native elements of these parts. They are, in all probability, a new and independent formation. They are, in the words of Prof. Paget, "primary or autogenous cysts." Such, it is my conviction, are the serous cysts of the kidneys. But I

must admit that reasoning and analogies are little to the purpose, except to show what is possible. After that, the question must be settled by observation and testimony. Dr. Johnson thinks he has seen the tubes breaking up into cysts, and believes he has seen the tubes "identical and continuous with them" (the cysts), with this modification, however, "the continuity only being *concealed* by the fibrous tissue in which they are packed." When I examine Dr. Johnson's figure, I think I have seen the appearance which he represents, and have convinced myself that the "bulgings" were independent cysts, and "the fibrous rings by which it (the tube) has been, in parts, constricted," are a part of the augmented intertubular matrix, separating primary and originally isolated growths. The prolongations, by his own statement not very obvious, I have never seen, or if I have seen them, they have been to my eye adjoining cysts, elongated somewhat as these kidney cysts often are; or a uriniferous tube which has been bent by the growth of a cyst and has resumed its course above or below in the line of the latter. I cannot say that I have distrusted my own observations on this point, for it has seemed to me, these many years, that I could demonstrate the facts, as I have seen them, to any person who had even a moderate familiarity with the microscope; but I was gratified to learn from Dr. Elliot that the late Dr. Isaacs, a year or more before his death, satisfied himself of the independent and primary origin of these cysts. In passing, it may be worthy of remark, that while Dr. Johnson is persuaded that new fibrous tissue has no important share in producing any of the characteristic features of chronic nephritis, he still finds that the uriniferous tubes are constricted by portions of the fibrous matrix. This would hardly occur, if this matrix were normal in quantity and healthy in quality. But this is aside from our present purpose. It is more apposite to inquire by what autoplasty the severed portions of the denuded tube are to unite to form a cyst. It is far from inconceivable that they may do so, but it would add to the strength of the theory, if, independent of the theory, they were shown to possess such a power. In dismissing this point, I will repeat that to my eye the cyst is a cell from the first; and add that these bodies, while they occur in many parts of the system, have a preference for new formed fibrous tissue, hence their occurrence in and about the indurated breast, in the fibrous hypertrophy of the intestines, in fibrous tumors, and, as I believe, in the adventitious fibrous tissue of kidneys affected with Bright's disease, yet nowhere showing any marks of being formed out of such tissues; that their occurrence in the neck, and the remarkable number that is sometimes seen in the kidneys, when these organs are not known to be affected with any form of Bright's disease, or any other disease but "cystic degeneration," renders it probable that no hypertrophy of the fibrous tissue is necessary for their production; and that the occurrence of uncomplicated cystic degeneration will, in the view taken by most pathologists, of the different behavior of old and new fibrous tissue, be fatal to Dr. Johnson's theory, if the cysts of this degeneration are admitted to be the same as those of the fibrous kidney.

There is still a question which the microscope ought to solve, but which to my mind is only partly answered. What causes the great enlargement of the kidney in Bright's disease? The granular degeneration of the cells does not materially enlarge the tubes, and consequently cannot greatly expand the kidney. The cells that become loaded with oil diminish the calibre of the tubes oftener than they dilate them, yet such tubes are often dilated. The oily deposit in the denuded tubes, though the latter are often large, affects only a limited portion of any kidney. Here then we seek in vain for the adequate causes of an augmentation which sometimes reaches four times the size and weight of the healthy organ. The intertubular deposits have been described as fibres, serous cysts, granules, and oil globules. The first two have, as a rule, no part in producing the enlargement. The fibrous formations contract the organ. It is only when the plasma is taking form or the fibres are incompletely consolidated, that the bulk of the material would add much to the general mass, and in this condition they are rarely, if ever, seen in the affection we are considering. The cysts are things apart, and as has been said, belong mostly to the fibrous kidney, though they are sometimes found in those that are larger than natural. It is to the granular matter and to the oil, among the visible deposits, that we are to look for the enlarged dimensions. That there is an infiltration of some sort into the structures is obvious. The cortical layer is often unnaturally thick, the pyramids are separated from each other by unusual spaces, and their external borders are made feathery by the exudation of new material between their elements. In kidneys which have become very large, I have sought in vain for such a quantity of either or both these substances as would fully account for the enlargement. Dr. Goodfellow attaches much importance in this connexion to a watery or œdematous state of the kidney, and thinks that the renal œdema precedes the general anasarca. "The serosity," he says, "drops from it (the large kidney) in large quantity as you make a section of it." (p. 60.) Watery kidneys, it is true, are not very uncommon, but I can assert positively that some of the largest I have seen have been firm and resisting to the finger, and have not been loaded with serum. I may add Dr. Goodfellow (p. 201) finds that "the tubes are empty and compressed in places, but in general are greatly distended with altered epithelium, mixed with granular matter more or less fine." These distended tubes would help to explain the augmented size of the kidney if they exist, but as I have already stated, in my examinations, for the most part, the distended condition has not been found in such degree as to be very important in this respect. Thus then the matter stands. I do not think we have yet a full explanation by the microscope of extraordinary enlargements of the kidney.

I will now offer a statistical report of the condition in which the kidneys were found in these thirty cases, on microscopical examination. We have already seen that there are symptomatic distinctions between the large and small kidney that are, at least in the extreme cases, pretty easily made out. We shall learn from this report that the lesions have no such distinct and separate characters, but that what happens to the large kidney happens also to the small, and that the organ becomes large or small through the agency of deposits that are common to both; the large or small size being the result of quantity and proportions, and also of the circumstances attending the exudations.

It will be remembered that among these thirty cases the kidneys were contracted in four; of nearly normal size in nine; and large, often white, in sixteen. We might expect an excess of the fibrous matrix in the four that were contracted, and not look for it in any of the others. It occurred, indeed, in these four, but it also was found in eleven that were not contracted thus:—

Fibrous matrix noticed in 29
Fibres, in unusual abundance, firm or granular, in . 15
" little or not at all increased, in 14

The weight of the kidneys in which the fibres were in excess was as follows, in ounces:—2½, 3, 4, 4½, 5, 5½, 7, 7, 7½, 8½, 9, 9½, 9½, and 12, embracing the smallest and the largest, and running through nearly all the intermediate sizes. The greatest excess was noticeable in those that were contracted. The weight of those in which the fibrous matrix was but little or not at all increased was as follows:—4, 4½, 4½, 4½, 5, 5½, 6, 6, 7, 7½, 8, 9½, 9½ oz. The average weight of the kidneys containing an excess of fibres was 6¼ ounces; of those not having excess, or doubtful, 5¼ ozs. But the kidneys weighing 9½ oz. had an abundance of fibres, and it was doubtful whether they ought not to have been transformed to the other class. Thus it appears that while this excess is the characteristic feature of the contracted kidney, it is seen in every gradation of size.

The granular degeneration of the epithelial cells was more frequently met with than fatty deposit in the cells, and

when they concurred in the same kidney, the granular degeneration was commonly the most marked.

Granular degeneration of the cells occurred in 24.
" " " did not occur in 6.

(To be Continued.)

CASE OF IMPENDING DEATH.

TREATMENT AND RECOVERY BY TINCTURE OF CANTHARIDES IN LARGE DOSES.

By JOSIAH A. B. MUSE, M.D.,

ATTENDING PHYSICIAN AND SURGEON TO THE U. S. GENERAL (MARINE) HOSPITAL, NEW ORLEANS, LA.

Benjamin Washer, æt. 30 years, came under my care, at this hospital, laboring under pulmonary tuberculosis. On Sunday, Sept. 7th, he became wildly delirious. Taking it, in view of circumstances, to be a case of tubercular meningitis, I treated it as such, and sedative treatment (qualified by supporting measures) was pursued, but without the least benefit, until symptoms of "prostration with excitement" became so unmistakably evident that all direct sedatives were abandoned, and a plan of treatment, from which they were scrupulously excluded was adopted. On the evening of Tuesday, Sept. 9th, however, he began to sink; he had not slept for three nights; no nourishment, since the first day, could be retained for a moment on the stomach. He continued steadily sinking until the time of my visit on Thursday morning, Sept. 11th, when I found him moribund. *Animal* life might almost be said to be extinct. The radial pulse was still perceptible, and diaphragmatic respiration was yet performed. The reflex action of deglutition could be excited only with the greatest difficulty, and the sphincters were all relaxed.

Prof. R. K. Browne, of New York, Surgeon-in-chief at this Hospital, had intimated to me, a short time ago, that he desired me to administer tincture of cantharides in the first desperate case of impending "death by asthenia" which should present itself in any of my wards. Although I did not consider this as a fair case for an experiment, inasmuch as I hardly expected the patient to live longer, I, however, drew his attention to the facts. At his suggestion I commenced the "heroic" use of tincture of cantharides, in doses of forty minims, frequently though irregularly repeated, according to the effect produced. The result was wonderful. In an incredibly short space of time (in the order of time in which I have enumerated them), warmth returned to the skin; the sphincter muscles regained their normal degree of tonicity; the "Hippocratic countenance" entirely disappeared; respiration was once more fully and equably performed; and every bad symptom vanished as it were by magic. Within three or four hours I had administered between two and three fluid drachms of the tincture. The patient enjoyed a refreshing sleep during the ensuing night. On the following morning he was in the calm possession of his mental faculties; took and retained amply sufficient nutriment, and was fairly on the high road to recovery. The tincture was given in diminished doses, and at length withheld, and the patient, on the Sunday following (Sept. 14th), had entirely regained his previous condition of health; his recovery having been more rapid than his decline, and without the least symptom of strangury having once made its appearance. It is the opinion of Dr. Browne that strangury will never occur in these extreme cases of debility, and that life may sometimes be saved at the last by this heroic remedy. In other cases he recommends it in combination, in smaller quantities, with other remedies, when a pure and powerful stimulant is needed.

Professor Hyrtl and Professor Hebra have received Exhibition medals; the first for his anatomical preparations, the last for a water-bed.—*Dub. Jour.*

Reports of Hospitals.

BELLEVUE HOSPITAL.

MITRAL DIRECT MURMUR, ILLUSTRATED BY CASES.

SERVICE OF DR. AUSTIN FLINT.

Auscultation has shown us that in organic disease of the heart the existence of four distinct murmurs can be clearly pointed out; these are the mitral direct and regurgitant, and the aortic direct and regurgitant. Concerning the three latter very little difference of opinion exists as to their frequent occurrence, but of the first named very many have denied its existence altogether. The following cases in which this murmur was known to have existed afford a sufficient opportunity for studying some of its characters.

The murmur is produced by the current of blood which is propelled over the mitral valve into the ventricle by the contraction of the auricle. As the contraction of the auricle immediately precedes that of the ventricle, it follows that the sound produced by that current must be pre-systolic, that it must be arrested immediately when the first sound takes place. The sound is generally harsh and of a blubbering and fluttering character, heard immediately before the first sound of the heart with no interval between. The condition which usually gives rise to it is that known asthe "button-hole slit," where the margins of the valves are adherent to each other. But there is no just reason to suppose that organic diseases always coexists with the sound, inasmuch as it may be produced when the valve is perfectly healthy. As proof of this fact it has been known to have been produced by aortic regurgitation, and Dr. Flint is disposed to explain its occurrence in the following ingenious manner. There being considerable insufficiency of the aortic valves, the ventricle is so filled with blood that the mitral curtains are floated up and the edges of the valves brought in contact, and while in this situation the auricle, contracting, throws the blood through the curtains, producing the peculiar blubbering sound. The murmur may again be produced, though very rarely, by the flow of blood over a roughened surface. The murmur is heard most distinctly at or a little within the apex beat, and its connexion with the first sound may be easily made out by placing the finger upon the carotid. The pulsations of this artery being, so to speak, synchronous with the first sound, the murmur will be found immediately to precede it. This serves, in a measure, to distinguish it from the diastolic murmur; but there will be found another important distinction to exist, being a well marked interval between the end of the second sound and the commencement of the murmur. This murmur may, as will be seen by a reference to the following cases, coexist with others—as for instance the mitral regurgitant. In that case the distinction between the two is for the most part very certain and satisfactory, the one being usually harsh and pre-systolic, the other following the first sound and very often being soft.

I.—*Mitral Direct Murmur and Enlargement of the Heart.*—Johannah D., æt. 24, was admitted Nov. 10, 1861. She stated that she had had two attacks of acute articular rheumatism, the first two years before, and the latter about nine months before admission. She had had cough and expectoration for three years, and repeatedly bloody expectoration for six or seven months. She had suffered from palpitation of the heart on exercise. On one occasion her appetite was poor, bowels regular, menstruation profuse, pulse eighty-six and small, respiration twenty-four and not labored; was subject to attacks of hysterical convulsions.

Physical Signs.—The apex beat was in its sixth intercostal space; impulse, also, in fifth intercostal space. The area of the superficial cardiac region was proportionably increased. A loud and rough pre-systolic murmur was heard, with its maximum of intensity at the apex, and extending a little to the outside of it. Over the body of the

heart it was distinct, but comparatively feeble. It could be heard over the whole surface of the left side, but became distant, less rough, as well as less loud, after a short distance without the apex. It was very loud within the apex. The murmur could be distinguished but indistinctly at the lower angle of the scapula, and on the left side, and in the left interscapular space.

The pulmonic second sound was somewhat louder than the aortic, which did not appear to be much if at all weakened. No murmur was found save the mitral direct. There was no turgidity of the cervical veins nor pulsation. No œdema anywhere; no distinct sign of tubercle. A tonic course of treatment was pursued, and the patient passed from under observation on the 30th of March.

II.—*Mitral Direct Murmur.—Aortic Regurgitant Murmur.—Enlargement of Heart.—Angina Pectoris.*—Anna S., aged 32, domestic, Ireland, was admitted during the month of May, 1861. She had an attack of acute rheumatism six years ago, and suffered from it for eleven months. Had no similar attack before or since. Dyspnœa first showed itself a year before admission, accompanied with pain in the præcordia, and palpitation, all of which was increased on exercise. On admission she stated that she was subject to paroxysms of severe pain in the præcordia, lasting from five to ten minutes, and extending to the left arm as far down as the elbow, accompanied by a cramping sensation in the left hand. During these paroxysms great palpitation occurred, and she experienced a sensation as if death were impending. These attacks occurred two or three times every alternate day, and seemed not to be produced by any exciting cause. She was able to be up and assist the nurse in her duties about the ward without much inconvenience. Her aspect was healthy, her appetite good, and menstruation regular. The pulse was 72, rather weak but not jerking, and the respiration was 20 per minute.

Physical Signs.—The apex-beat in the sixth intercostal space on a line with the nipple, the impulse being felt in the fifth, fourth, and third. There was no heaving of the præcordia, but a sharp shock was communicated to the hand. An aortic regurgitant murmur was heard loudest to the left of the median line, a little below the level of the nipple. There was also a feeble rather indistinct aortic direct murmur at the base on the left side, but not on the right. This murmur was not recognisable in the carotid. A mitral direct murmur (rough) was heard a little within the point of the apex-beat. No mitral regurgitant murmur existed. There was no murmur in the carotid anterior to the sterno-cleido mastoid, but a loud one below and posterior to this muscle on both sides. The first sound over the apex was notably loud, long, and booming, and was propagated loudly into the carotids. The pulsations of the carotids were visible, but not markedly so. No turgidity of the cervical veins. The patient's condition remained for the most part unchanged up to the 30th of March, when she passed from under observation.

III.—*Mitral Direct, Aortic Direct, and Aortic Regurgitant Murmurs.—Paralysis of the Left Upper and Lower Extremities (Embolus?)—Epileptic Convulsions.—Danger of Death from Chloroform.*—Mary Austin, aged 24, was admitted in August, 1860. She was the mother of one child. She suffered from an attack of acute rheumatism four or five years before admission, and was confined to her bed four months. About a year after she recovered from the rheumatism, she became suddenly paralysed in the left upper and lower extremity. The face was not affected. When admitted to the hospital she recovered from this difficulty so as to use her left arm, but the leg of the corresponding side was still more or less affected.

About eight months after the attack of paralysis she began to have convulsions, which, from the description she gave, were undoubtedly epileptic. She would have a great number of these attacks in rapid succession, and on one of these occasions chloroform was resorted to by Dr. Thomas, and she came so near dying from the anæsthetic, that for a time she seemed to be dead. For two years she had palpitation and dyspnœa on exercise. During her stay in the hospital she was subject to pains in the præcordia, extending to the left shoulder and down to the elbow. Pulse 100, respiration 36. Appetite was good, but bowels were constipated. The treatment consisted in the administration of ethers, laxatives, and occasional dry cupping.

Physical Signs.—The heart was moderately enlarged, the apex beating in the sixth intercostal space without the nipple. There was considerable shock over the præcordia but no heaving. An aortic direct murmur was heard at the base of the heart on the right side—it was feeble, low, and somewhat rough, being propagated into the carotids. A soft, feeble, aortic regurgitant murmur was heard at the left of the sternum over the body of the heart. A very loud, rough, and characteristic mitral direct murmur was heard around the apex. No mitral regurgitant murmur discoverable. The aortic second sound was notably weakened, and the pulmonic sound notably intensified. On the 30th of March, the time the last note was made, the patient's condition was about the same.

Reports of Societies.

NEW YORK ACADEMY OF MEDICINE.

STATED MEETING, April 16, 1862.

DR. JAMES ANDERSON, PRESIDENT, IN THE CHAIR.

DISCUSSION ON PELVIC HÆMATOCELE.

DR. J. BYRNE, of Brooklyn, read a paper on "Pelvic Hæmatocele," of which the following is an abstract.

After briefly alluding to the earlier history of bloody tumors of the female pelvis, the author confines himself principally to a review of the literature of the subject from 1850 down to the present time. Though the escape of blood into the retro-uterine cul-de-sac of the peritoneum has been noticed for a long time by various observers, yet but few well authenticated cases of encysted pelvic hæmatocele are to be found recorded previous to 1850, and "*even yet some of our standard works on the diseases of females deny the subject a single chapter.*"

The principal, if not the only authors in Great Britain, who have written anything on the subject, are Drs. Tilt and West, and Professor Simpson, and in America, Professor Bedford, who has reported a very interesting case in his work on the diseases of females.

To French physicians, therefore, almost entirely, and to Professor Nelaton in particular, are we indebted for our knowledge of the disease; and the discussions and essays which followed his investigations, prove not only how little the malady has been studied, but also how much we have yet to learn of its true pathology. Much diversity of opinion seems to exist regarding the source of the hæmorrhage, and consequently the relative location of the tumor in hæmatocele; some contending that the effusion takes place, for the most part, either from the peritoneal surface of the ovary or the abdominal orifice of the fallopian tube, and therefore into the recto-uterine cul-de-sac of the peritoneum; and others, that the utero-ovarian veins are the seat of the effusion, and that the sub-peritoneal cellular tissue will be found to be more frequently the pathological nisus in such cases.

The author of the paper discusses at some length the various opinions on these important questions, and regards the pathological changes observed in cases of death as of little value in a statistical point of view, because the majority of intra-peritoneal extravasations must necessarily be fatal, and hence he believes that the sub-peritoneal form of hæmatocele is by far the more frequent.

Exception is taken to the opinion of most, if not all, previous writers on this disease regarding its connexion with "*disordered menstruation*," which latter the author seems to consider as one of the consequences of some pre-existing pa-

thological condition in the ovary or neighboring tissues; because, though admitting that hæmorrhage "to a limited extent," from one or more of the Graafian vesicles, may take place, yet sufficient blood to produce even a moderately-sized retro-uterine tumor cannot be extravasated from a healthy ovary, or a tube whose lining membrane is free from structural lesions.*

The "*ovarian irritation*" of Drs. Bennet, West, Churchill, and others, though often the result of uterine inflammation, is, nevertheless, frequently a primary affection, depending on inflammation of the ovary and neighboring tissues.

The causes are divided into *predisposing* and *exciting*, as follows:—(1st.) Inflammation of the uterine appendages, and its consequences. (2d.) Habitual constipation of the bowels, and morbid growths interfering with the free return of venous blood, and thereby producing a varicose condition of the vessels. (3d.) A hæmorrhagic diathesis from a disordered state of the blood. (4th.) Tubular, uterine, or vaginal occlusion, obstructing the normal secretion or giving rise to regurgitation through the Fallopian tubes. The immediate or *exciting causes* may be, (1st) sudden suppression of the menstrual, or a hæmorrhoidal discharge; (2d) tenesmus or violent muscular exertion; (3d) injuries by a fall or otherwise, and (4th) excessive coitus, and mental emotions tending to active congestion of the internal organs of generation.

Still another cause remains to be mentioned, which might with propriety be classed both as predisposing and exciting, namely, extra-uterine pregnancy.

When the hæmorrhage takes place from the under surface of the ovary, or within the folds of the broad ligament, the patient having previously suffered more than usual from pain in one or other iliac region, will complain suddenly of severe cramp in the lower portion of the bowels, accompanied or soon followed by tenesmus, and weight referred to the loins and sacrum; there may be painful and difficult micturition, and if the quantity of blood poured out be great, faintness, and even complete syncope may now take place; the skin assumes a pale or sometimes anæmic hue; the extremities become cold, the countenance anxious, pulse small and frequent, and the abdomen tympanitic, and very sensitive to pressure, particularly over the seat of the rupture. At this stage of the case, a vaginal examination will rarely fail to detect a tolerably firm and irregular tumor, somewhat painful to the touch, and situated directly behind, or to either side of the uterus.

[A full report of what the author considers a case of subperitonæal hæmatocele of "the most exaggerated type" is referred to, but our space will not permit us to do more than allude to it; we can merely refer our readers to the original paper for its minute and instructive details.]

When the flow of blood takes place into the retro-uterine cul-de-sac of peritoneum the symptoms will of course be most alarming. The pain referred to the hypogastrium will be more intense, and the collapse more complete and enduring; the abdomen rapidly becomes tympanitic, and vomiting of brown or dark grumous liquid, now incessant, adds much to the distress of the patient; the pulse, if perceptible, is very small and rapid, and the features assume a hippocratic expression. Voisin, referring to the frequent absence of premonitory signs indicative of the occurrence, says, that "the suddenness of the symptoms has sometimes led to the suspicion of poisoning."

The Diagnosis of hæmatocele is in most instances extremely difficult, as proved by the case of M. Malgaigne, as well as those of other observers. And referring to this part of the subject, Nélaton says, "the first case which I saw, I pronounced encephaloid disease, and incurable;" and of the second he adds, "I reflected a long time, and concluded at last to introduce a trocar: if *cancer*, it could do no harm, and moreover, I had an idea that it might prove to be *abscess*."

If, however, a careful inquiry be made into the previous history of the case, it seems hardly possible to make such grave mistakes; because, malignant growths, at least, and hæmatocele, present so few symptoms in common, that unless in a very anomalous case of the latter, which might possibly exhibit some extraordinary features and complications, such an error of judgment would seem to argue great remissness on the part of the professional attendant.

The *principal* diseases with which it might be confounded, are, *pelvic abscess, retroversion of the uterus, dislocated ovarian cysts or fibrous tumors, and extra-uterine fœtation.*

Suppuration will, for the most part, be ushered in by much constitutional disturbance, manifested by fever, rigors, &c. The swelling is more painful to touch, and gradually increases in size, and becomes softer. Whereas, *in hæmatocele the tumor is immediately formed*, and in the course of time may become less sensitive, and in all cases more firm.

Retroversion at first sight might be mistaken for hæmatocele or vice versâ, but the position, or rather direction of the os and cervix, and other features diagnostic of this displacement, render it hardly possible to entertain doubts on this point after mature reflection: should some peculiarities represent, however, tending to excite suspicions one way or other, the introduction of Simpson's sound will be the most unequivocal means of arriving at a correct inference.

Ovarian cysts are less likely to be mistaken for hæmatocele than fibrous tumors, because, though their sudden displacement into the retro-uterine region might give rise to symptoms very analogous, yet in the former, the swelling will be more isolated and to a certain extent easily defined, movable, and situated pretty high up in the vagina: the uterus will also admit of being moved independently of the tumor, especially if the sound be used; and lastly, there will be no sudden anæmia.

Fibrous tumors in the posterior uterine wall, being intimately connected with this organ, might, if examined without reference to the previous history of the case, be mistaken for hæmatocele, but with ordinary diligence in our investigation such an error would seldom if ever occur.

Extra-uterine pregnancy, in some of its characters, might resemble retro-uterine hæmatocele, but the mildness of the symptoms, some of them perhaps being those referable to ordinary pregnancy, the slowness of their development, and the detached and movable nature of the tumor, ought to distinguish it from an *encysted* hæmatocele at least.

The mistakes of Nelaton, Robert, Huguier, Dupuis, Stoltz, and Malgaigne, are referred to by the author, in proof of the great difficulty with which an accurate idea of the nature of these tumors can be arrived at in some cases. "A correct diagnosis will often be impossible until the trocar shall have entered their walls."

TREATMENT—Should be threefold—preventative, palliative, and curative.

If the author be correct in attributing these maladies to inflammation of the ovary and varicose veins within the folds of the broad ligaments, "*preventative treatment* demands *our first and most earnest attention.*" This will be best accomplished by local depletion, counter-irritation, and gentle laxatives.

Palliative treatment would consist in restoring the equilibrium of the circulation, combating the peritonæal complications by local depletion and other antiphlogistic measures, relieving pain by anodynes, and supporting the patient by proper nourishment.

(To be Continued.)

DANTE.—The *Patrie* has made the notable discovery that Dante, the great Italian poet, was an apothecary. The name of the illustrious poet has been found in a register of the 15th century, figuring in a list of physicians and chemists, and inscribed in the number of the latter in 1282.—*Dub. Med. Jour.*

* It is hardly necessary to state that the author does not question the fact, that menstrual regurgitation may give rise to *intra-peritonæal* collections.

American Medical Times.

SATURDAY, OCTOBER 25, 1862.

TRIAL OF MRS. REAL.

The public in general was much interested last week in this trial. The medical profession had a still greater interest, which was to know whether the plea of moral insanity given by the accused (Mrs. Real) who had shot and killed her alleged husband, would be admitted or rejected. The celebrated Mr. James, late of London, was the defender; and Mr. Hall, District Attorney, though much younger, no less a lawyer of great learning and ability, was the prosecutor in the name of the people of New York. Now that a verdict of manslaughter in the third degree, with mitigating circumstances, has settled the question of moral insanity for a long time, we hope, it becomes the duty of the medical press to note how the medical evidence was understood and appreciated by the jury and the court, and finally, what were the grounds of accusation and defence, as well as the charge of the judge relating to moral insanity. The jury followed the opinion of the physicians, who declared they could find no symptoms of insanity; therefore we have only to examine the opinions of the learned gentlemen of the church and the bar.

It appears that several psychopathists had been subpœnaed, but on the suggestion of the Honorable Judge Barnard, two of our chief physicians and superintendents of lunatic asylums were called on the stand. Dr. Moses H. Ranney was the first physician examined; his evidence was clear, logical, and entirely scientific. It may be summed up in a few words—To prove the moral insanity of a person who has committed a crime under the influence of that disease, physical and mental signs must be recognised, and no physician of an asylum can rely on legal affidavits when he admits a patient into a lunatic ward. The defence wished to show that it was necessary to have seen the effect which the meeting of the prisoner's husband with another woman might have had on her impulses of volition, without which it appeared impossible to give an opinion on her sanity. But, we must observe that the defence, in saying this, pleaded a *transitory homicidal mania*, which is incompatible with the alleged *moral insanity;* such contradictions of the defence, and many other proofs of a complete ignorance of medico-legal psychiatry, have passed unobserved by jurists in this trial.

A curious incident happened in Dr. Ranney's cross-examination; a simple question, presented in an incidental form, remained almost without answer; the defence wished to know whether the demeanor (carriage, deportment, behavior) of the accused, as presented by the District Attorney, was consistent, before and subsequently to the act, with her nervous predisposition, her mental afflictions and perversions (suicidal), and with her frenzy when she met her alleged husband with another lady. This question had in view to establish a *transitory* homicidal mania—a disease almost impossible to imagine, since there are no prodroms, no phases of increase or diminution, *and no physical signs.* It is true, in certain manias and special diseases of volition, sudden attacks are remarked, but they are always preceded, accompanied, and followed by symptoms which leave not the slightest doubt as to their nature.

Dr. David Tilden Brown, of the Bloomingdale Asylum, gave a correct and just evidence; he stated that he concurred in general terms with Dr. Ranney's definition of moral insanity, which required symptoms both mental and physical. He said that he had found no indication of insanity in the case related by the District Attorney, and yet all these acts might be performed by an insane person; he saw nothing in the statement of facts that showed sanity or insanity; but such might not be his opinion if all the facts had been stated. Everybody, and certainly the jury, appreciated fully the just and humane reserve of Dr. Brown. The facts wanted were the symptoms legally observed and described at the moment of the commission of the manslaughter.

Instead of the invidious opposition which is so often noticed in the English courts, we have seen two physicians performing their difficult duty with the respect they hold to themselves and the medical profession.

We need not mention the talents, learning, and eloquence of Mr. James the defender, and of Mr. Hall the District Attorney. The Honorable Judge also made a very eloquent speech when he charged the jury; but, unfortunately, coming to the evidence given by our medical brethren, he said, "as to the medical testimony he did not consider it material; indeed he never deemed it important, for you seldom find two doctors agree except they belong to the same school."

Accordingly the Honorable Judge gave to the jury a medical opinion of his own as follows:—"There are two kinds of insanity; a permanent, total, and visible one, discoverable by acts, looks, manners, and conversation; or an impulsive one, that renders a person wholly irresponsible for every act termed lunacy. And the other insane on particular subjects not always visible, unless occasion offer, like Pyromania, Kleptomania, or what has been termed by recent writers impulsive insanity." Then his Honor said he had had the opportunity of seeing a remarkable instance of Kleptomania in Europe, and related it to the jury. We regret that a Judge on the Bench should indulge in medical theories which are not within his province. Especially is this true of a Judge who holds the following opinion. "I can conceive of a person who might not be accountable to his Maker and yet be perfectly accountable to human tribunals." This is a false theory: First, because God is the Supreme Justice, and human tribunals have been stained by the blood of many innocents, sane and insane; Secondly, because it admits that insanity, if only partial in its appearances, does not absolve the offender, or that the state of insanity must be permanent to admit irresponsibility.

If Mary Real had been insane she would have had many defenders in our profession; but as the facts existed, and were presented before the Court, she found impartial justice and pity from the physician, and justice and mercy from the court and jury.

THE WEEK.

In the Students' Number we published the regulations for admission and promotion in the Navy. We were not aware at the time of any more recent legislation on this subject than the Act of 1835. In another part of this

number will be found a copy of the Act of 1860, for which we are indebted to the courtesy of Surgeon Whelan, chief of the Bureau of Medicine and Surgery of the Navy Department. It will be seen by the table of compensation that the naval service offers great inducements to the recent graduate. We may add that the examination is at the same time rigid and fair; it embraces the classics, every branch of the physical sciences, and every department of medicine. To the student of high aims, who despises mediocrity, as every student ought, such a test of his capacity is but a healthful stimulus to exertion.

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The lectures in the medical schools of New York are now all in progress of delivery. The attendance of students is, as we had anticipated, larger than last year, and the aggregate number is most flattering to the future state of medical teaching in this city.

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The medical examiners of persons claiming exemption from the draft for physical disability, have been busily engaged in performing their duties in this city and Brooklyn during the past week. It is very generally remarked that few present themselves who have not real cause. The majority of diseases alleged are apparent, and require but a moment's examination to determine their nature. From present appearances not more than five per cent. of all who allege disability make false claims.

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Pelvic hæmatocele is a disease to which hitherto but little attention has been directed by the profession, and consequently very little has been said upon this subject. It is for this reason that we call the attention of our readers, more especially those interested in the subject of uterine pathology, to the discussion upon this disease before the N. Y. Academy of Medicine, which we commence in this number by an abstract of Dr. Byrne's paper. We are confident that all who follow up the perusal in the succeeding numbers will be interested and instructed.

VERMONT MEDICAL SOCIETY.

This Society held its Annual Meeting at the State House, Montpelier, Wednesday and Thursday, October 15th and 16th, the President, Dr. A. S. Woodward, of Brandon, in the Chair. The Record of the last meeting having been read and approved, the Chair appointed Dr. S. Woodward, of St. Alban's, Clark, of Montpelier, and Stiles, of Windsor, a Committee on Credentials; and Dr. S. Chandler, of S. C., Albany, Russ, of Pomfret, and Houghton, of Pawlet, a Committee on Nominations.

The following gentlemen were elected members, D. R. Story, M.D., Proctorsville; N. W. Fairchild, M.D., Fulton; Geo. W. Nichols, M.D., Bethel; C.H. Tenny, M.D., Hardwick; E. G. Judkins, M.D., Waitsfield; E. P. Fairman, M.D., Walcott; J. E. Frink, M.D., Waterbury; W. W. Braley, M.D., Chelsea; T. G. Simpson, M.D., Vershire; H.F. Crane, M.D., Ferrisburgh; Danl. C. Joslin, M.D., Waitsfield; Lester Kingsley, M.D., Moretown.

The credentials of Dr. Edwin M. Snow, Delegate from the R. I. Medical Society, were presented, and Dr. Snow was invited to sit with the Society and participate in the deliberations of the same. The following resolution was adopted: *Resolved*, That this Society send a Delegate to each New England State Society, and also to the N. Y. State Society, at their Annual and Semi-Annual Meetings, and report to this Society at its next subsequent meeting.

In accordance with a suggestion by Dr. Stiles, each member was called upon by the President for a statement of the diseases prevalent in his own practice and vicinity. Dr. Snow, the delegate from R. I. was called upon, and made some interesting remarks upon the condition of the R. I. Societies, and other matters of like connexion.

A great portion of the afternoon was taken up in the discussion, by members, of various diseases which have come to their attention. The following was adopted: *Resolved*, That each Member of the Society (in practice) be requested to report a written case treated by himself, at the Annual and Semi-Annual Meetings of the Society, said Reports to be kept on file by the Secretary, with a view to their publication with the Transactions of the Society.

Thursday, Oct. 16, 1862.

The Society met, pursuant to adjournment, the President in the Chair. The Committee on Nominations reported the following named gentlemen for officers for the year ensuing, which Report was accepted and adopted.

For President.—J. N. Stiles, M.D., Windsor.

For Vice-President.—A. S. Houghton, M.D., Pawlet.

Record. Sec'y. Wm. McCollom, M.D., Woodstock.

Cor. Sec'y. C. B. Chandler, M.D., Montpelier.

Lib. & Treasurer. Chas. Clark, Montpelier.

Delegates to Castleton Medical College. J. L. Chandler, M.D., St. Alban's, and Cullen Bullard, M.D., New Haven.

Delegates to Burlington Med. College. A. C. Welch, M.D., Williston; T. G. Simpson, M.D., Vershire.

Committee on Printing. H. F. Stevens, M.D., St. Alban's; C. L. Allen, M.D., Middlebury; and Joseph Perkins, M.D., Castleton.

Executive Committee. E. N. S. Morgan, M.D., Poronal; W. H. H. Richardson, M.D., Montpelier; and J. Crowley, M.D., Mount Holley.

Delegate to the New York Medical Society. R. C. Woodward, M.D., St. Alban's.

Delegate to R. I. Medical Society. Wm. McCollom, M.D., Woodstock.

Delegate to the Conn. Med. Society. J. N. Stiles, M.D., Windsor.

Delegate to Mass. Medical Society. C. M. Rubler, M.D., Montpelier.

Delegate to Maine Medical Society. Joseph Perkins, M.D., Castleton.

Delegate to N. Hampshire Medical Society. E. A. Knight, M.D., Springfield.

The following resolution was adopted:

Resolved, That the Vermont Medical Society recommend to the Legislature of said State, to authorize the Governor of the State to send to the Regiments of Vermont as many of the Lambert's new and Improved Tourniquets, as he in his judgment may deem best.

The following resolution was adopted:

Resolved, That this Society recommend to the Governor that the Board of Surgeons to examine Candidates for Regimental and Assistant Surgeons, be appointed from those of the profession who are not interested directly in our medical schools; and that the Secretary be instructed to transmit a copy of the resolution to the Governor.

Voted that the semi-annual meeting of the Society be holden at Woodstock, at such time in the month of June next as the Secretary shall designate.

The Annual Address by the President was delivered on Wednesday evening, in the Representatives' Hall, and was listened to with an attention rarely elicited on such occasions.

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We observe that the "Société Universelle d'Ophthalmologie," of which Dr. Sichel is the President, will hold its next session in Paris on the 30th of the present month; and on the 1st, 2nd, and 3rd of October; in the Salle du Grand Orient de France, 16, rue Cadet. Cards of admission to the different sittings will be delivered on September 29th, from noon till four o'clock p.m.; and on the first day of the Session, from eight till ten o'clock a.m., at the house of the Secretary, Dr. Weeker, 3, Faubourg St. Honoré.—*Dub. Med. Press.*

Correspondence.

FOREIGN CORRESPONDENCE.

LETTER XIV.

By PROF. CHARLES A. LEE.

MINERAL SPRINGS.

VICHY, Aug. 9, 1862.

I HAVE already stated enough regarding the mineral waters of Vichy to show that they are not only more frequented by invalids than others in France, but probably also in Europe. There are other places to which the fashionable world more generally resort, as Baden; but none which attracts so many for the simple purposes of health.

The hospitals of the place, perhaps, deserve more particular notice. The Military Hospital is a very handsome structure, designed to accommodate one hundred and fifty patients, of whom about ninety at present are officers, and sixty subalterns and soldiers. The average duration of the water treatment for each patient is forty days; so that nearly six hundred individuals connected with the army are subjected to it every season. Every officer has a conveniently furnished room, and there are commodious and well fitted up dining and assembly rooms, etc. Indeed, I have never seen anything superior to the arrangement of the piscinæ, baths, and douches—the latter being worked by a compressed air machine by steam power; one spring, *Lucas*, rises near to the hospital, and this is connected with another (*des acacias*) which formerly had a separate outlet. Behind the thermal establishment, and beneath the peristyle, are three other springs, viz. the *Puits Chomel* in the centre; the *Grand Grille*, rising in a large railed basin at one end; and the *des Mesdames*, to which the water is conveyed by tubes, at the other; while adjacent to the establishment is a building containing reservoirs for cooling the water used for the baths, and the laboratory where the Vichy Salts are manufactured.

Besides this, there is a Civil Hospital under the charge of the Sisters of Charity. The thermal establishment connected with it also contains numerous bath-rooms and douches, supplied by the hospital spring already mentioned, which rises in the court in a large circular basin surrounded by a handsome railing.

The principal establishment is of white fine-grained sandstone, one story high, built with considerable architectural taste, its principal façade, with arcade, fronting the Park, the ground-floor being occupied by the numerous bathing rooms, on either side of spacious galleries and waiting rooms, conveniently fitted up, the bathing tubs being of copper lined with tin. One side is appropriated to ladies, the other to gentlemen. The first floor, as it is called, is consecrated to recreation, having a large ball-room; a music rotunda, where Strauss's band plays every day, and where concerts and other entertainments are given; and a small theatre for vaudevilles and other light dramatic productions. There are also reading, billiard, and card-rooms, etc. There are over seventy hotels and one hundred lodging-houses in Vichy, and generally they are all filled during the bathing season. Hearing I might not find accommodations, and seeing a large sign over a spacious Caravansary, "GRAND HOTEL OF THE UNIVERSE," I at once concluded there would be sufficient room there for me, and I was not disappointed; for, in the "*quatrième étage*" I found a snug, well furnished cabinet, which I at once appropriated; and this was the last vacant space in the whole "Universe."

There are spacious dining-rooms in all these hotels, and a *table-d'hôte*, at which from sixty to a hundred or more dine; they also are furnished with large saloons where the boarders or lodgers meet and pass the evening with occasional music, dancing, etc. This is a great improvement on the German baths and watering-places, which only have their public *Cursaals*. There are frequent *reunions* at the different hotels, and public balls weekly, while the band plays every day in the park, and in the music saloon in the evening. The great objection to the place, however, to me, is its excessive heat in July and August, to say nothing of the dust when the wind blows.

At present, there are eleven distinct springs or fountains, all highly alkaline, and all of an elevated temperature, except three, viz. Celestins, Lardy, and Mesdames. The *bicarbonate of soda* is the principal ingredient, and nearly all are used both for drinking and bathing. It has been ascertained that if the earth for some distance around the springs is penetrated to the depth of ten *kilometres*, analogous mineral water is discovered; so that the soil beneath the argillaceous layer that lies above may be regarded as a sponge which receives the mineral waters in their ascent, and transmits them to the surface either by means of natural artesian wells, or through boring tubes. It is computed that the amount of salt daily supplied by the springs, most of which is lost in the allier, amounts to more than 5,100 kilogrammes. The temperature of these springs, as well as the amount of salts contained in them, varies somewhat at different times. For instance, the Grand Grille, which is by far the most important of all, had a temperature in 1743 of 48 (centigrade); in 1820, of 38; in 1844, 32; in 1848, 42. The temperature of the other springs at present is as follows: Puits carré, 45; Puits Chomel, 42; Hôpital, 31; Lucas, 30; Celestins, 22; Lardy and Mesdames, 22. The water of the warm springs is perfectly limpid, without smell, and of a strongly alkaline and slightly acidulous taste, though immense quantities of carbonic acid gas are given off, especially by the Grand Grille—and yet it does not sparkle at all in the glass. The strongest springs, as Lucas, Puits Carré, and Celestins, contain about 45 grains of soda to the pint of water. The Puits Carré, used exclusively for baths, contains in a LITRE, or two pints 17 cubic inches of *carb. acid*; 90 grs. *bi-carb. soda*; 10 grs. *muriate of soda*, and 8 grs. *sulphate of soda*; with small quantities of lime, magnesia, silex, iron, and a vegeto-animal substance *glaieine*, which is seen to cover the edges of the basin of the hospital and some of the other springs. Some, as the Lucas, are slightly impregnated with sulphur, and some, as the Hauterive and Des Dames, contain a considerable amount of the bicarbonate of protoxide of iron—all contain a trace of organic matter.

As to the remedial properties of the Vichy, all agree that they are highly alterative and diuretic. Although the bicarbonate of soda is undoubtedly the principal active ingredient, yet the same effects are not produced by the same quantity of the salt dissolved in water, which shows that the water is not a simple alkaline solution, but a peculiar compound, which cannot be exactly imitated. This may either be owing to its containing substances not revealed by analysis, or to the peculiar mode of combination.

The urine is said to be rendered alkaline after drinking three or four glasses, or even after taking a protracted bath. Patients generally are directed to bathe in, as well as drink the water; though for the former purpose it is generally diluted with common water to prevent its being too stimulating.

The waters are believed, by those who have resided on the spot and watched their effects for years, to be adapted to a variety of pathological conditions—a much greater, indeed, than would be inferred from their chemical analysis. The most experienced physician here says, you cannot tell, *à priori*, what their precise effects will be, each case must be studied by itself, and we have to feel our way through the whole course. This is probably pretty near the truth, and will apply to other mineral waters besides those of Vichy. The principal water drunk is that of the Grand Grille, which has a high temperature, and it seems to me that a good deal of the effects may be attributed to this circumstance. Most of those who drink it tell me that it does not operate at all on the bowels, but excites the appetite and improves the digestion, while it always acts more or less on the kidneys. These effects were verified in my own case. I am satisfied, however, that too much of the

water is often drunk, for those who indulge very freely in its use often complain of a sense of giddiness and fulness about the head, sleepiness, stupidity, unpleasant sensations about the liver or kidneys, with a sense of weakness and general loss of tone. Patients too often go on the principle that if a little does good, a great deal will do still more; and so, by excess, defeat the very object in view. There can be no doubt, I think, that a general cachectic condition, attended with great debility, may and often does exist from the excessive and too protracted use of these alkaline waters. Many come here and drink them freely without consulting any physician, to save expense, and the consequence is they lose what health they had when they came, and then abuse the waters for their own imprudence. The fact is, that mineral waters are generally used with too little care and discrimination, for they are powerful agents for good or ill. Trousseau has specially alluded to the abuse of these waters in the treatment of gout, for which they are generally recommended, even in debilitated states, and where there is a tendency to a cachectic condition, or even dropsical effusion. In all such cases they must do more or less mischief. In opposite states, attended with acidity of the secretions, and too great plasticity of the blood, they may, if used moderately, prove beneficial. Where stimulants are freely used and too much animal food taken, small doses of Vichy water counteract to a considerable extent the injurious effects they might otherwise produce. They are, however, far from being as prejudicial or dangerous as a simple alkaline solution of the same strength. These waters are generally recommended by French physicians in gout, and a variety of deranged states of the digestive organs, abdominal engorgements or obstructions, chronic enlargements of the liver and spleen, the sequelæ of intermittents and remittents, slow fevers from chronic affections of the mucous membrane, acidity of the stomach, calculus and other diseases of the urinary organs, uterine derangement, and in some cases of chronic rheumatism and cutaneous affections. But the proper application of these waters, I am satisfied, is a great science, and requires vast experience. Each spring is a study in itself. Each case is experimental. In a gentleman, for instance, in Paris, in whose case I was consulted, and who was troubled with pains in the lumbar region and irritation of the urinary organs, the least quantity of Vichy water increased the pain and irritation, and nothing was found to afford so much relief as flax-seed tea and slippery elm. I may refer to this subject again when I come to speak of the Carlsbad and other German mineral waters of the alkaline kind.

But I have not space to enter on this subject at length, which would require no small-sized volume to do it justice.

It is a significant fact that those best acquainted by experience with the effects of the Vichy waters, prescribe them in fewer cases, in smaller quantities, and with greater caution than any other practitioners. But is not this the case with all physicians, and in regard to all powerful remedies?

Army Medical Intelligence.

LIST OF THE NAMES OF SURGEONS AND ASSISTANT SURGEONS APPOINTED TO THE VOLUNTEER REGIMENTS OF THE STATE OF NEW YORK, SINCE MAY 31, 1862, AND THE CHANGES WHICH HAVE OCCURRED IN THE REGIMENTS IN THE FIELD FROM THE SAME DATE.

(*Continued from page 223.*)

Sept. 1st.—Edwin Amsden, Assist. Surgeon 2d Regt., 30th Dist., (new Regt.); Edgar C. Bass, Assist. Surgeon 2d Regt., 19th Dist. (new Regt.); Carey W. Howe, Assist. Surgeon 116th Regt., 31st Dist., (new Regt.); Charles F. Warner, Assist. Surgeon 2d Regt., 30th Dist. (new Regt.); John C. Patterson, Assist. Surgeon 130th Regt., 30th Dist. (new Regt.) Sept. 2d.—Henry Duane, Assist. Surgeon 59th Regt.; William B Eagan, Jr., Surgeon 3d Regt. Metropolitan Guard (new Regt.); Joseph L. Hasbrook, Assist. Surgeon 4th Regt. Empire Brigade (new Regt.) Sept. 3d.—John Knowlson, Surgeon 2d Regt., 12th Dist. (new Regt.); Charles Bruenninghansen, Surgeon 119th Regt. (new); John M. Farrington, Surgeon 2d Regt., 24th Dist. (new Regt.); Jeffrey R. Thomas, Assist. Surgeon 112th Regt., 32d Dist. (new Regt.) Sept. 4th.—George B. Parker, Assist. Surgeon 42d Regt.; John A. Robinson, Assist. Surgeon 38th Regt.; Marvin C. Rowland, Assist. Surgeon 61st Regt.; Robert V. K. Montfort, Assist. Surgeon 124th Regt., 9th Dist. (new Regt.); Asahel Burt, Jr., Assist. Surgeon 139th Regt., Col. Conk's (new Regt.); Elbert M. Somers, Assist. Surgeon 2d Regt., 19th Dist. (new Regt.); Arnold Stubb, Assist. Surgeon 90th Regt. Sept. 5th.—Augustus C. Walker, Assist. Surgeon 2d Regt. Metropolitan Guard (new Regt.); Rykeman D. Bogert, Assist. Surgeon 135th Regt., 8th Dist., (new Regt.); Edward G. Marshall, Assist. Surgeon 124th Regt., 9th Dist. (new Regt); Albert Utter, Assist. Surgeon 36th Regt. Sept. 6th.—William B. Schermerhorn, Assist. Surgeon 37th Regt.; Wesley T. Rice, Assist. Surgeon 142d Regt., 17th Dist. (new Regt.); Orestes C. Gibbs, Assist. Surgeon 21st Regt., vice Joseph A. Peters, promoted; John Dwyer, Surgeon 69th Regt., Corcoran's Brigade (new Regt.); George G. Benson, Surgeon 2d Regt., Columbia Co. (new Regt.); John Monypenny, Surgeon 123d Regt., Washington Co. (new Regt.) Sept. 8th.—Silas S. Cartwright, Assist. Surgeon 134th Regt., 14th Dist. (new Regt.); Calvin H. Carpenter, Assist. Surgeon 148th Regt., 2d Regt. 26th Dist. (new Regt.); Louis Applegate, Assist. Surgeon 102d Regt. Sept. 9th.—Morgan Lewis, Assist. Surgeon 82d Regt.; David Larrabee, Assist. Surgeon 86th Regt.; Lewis Darling, Surgeon 3d Regt., 27th Dist. (new Regt.); James F. Ferguson, Surgeon 2d Batt., 5th Regt. (new); Edward Storck, Surgeon Buffalo German Regt. (new); Willard R. Fitch, Assist. Surgeon 82d Regt., vice James F. Ferguson, discharged. Sept. 10th.—Edward C. Mundy, Surgeon Col. Minthorne Tompkins' Regt. (new); Henry G. Bates, Assist Surgeon 131st Regt., 1st Metropolitan Guard (new Regt.); Stephen G. Cook, Assist. Surgeon 150th Regt., Dutchess Co. (new Regt.) Sept. 11th.—James R. Leal, Surgeon 144th Regt., Delaware Co. (new Regt.); Cornelius B. O'Leary, Assist. Surgeon 145th Regt., Col. Allen's (new Regt.); Samuel H. Olmstead, Assist. Surgeon 4th Dist. Regt. (new); Stephen S. Lounsbery, Assist. Surgeon 4th Dist. Regt. (new); Richard S. Connolly, Assist. Surgeon 123d Regt., Washington Co. (new Regt.); John W. Gray, Assist. Surgeon 98th Regt.; Miles Goodyear, Assist. Surgeon 82d Regt.; Andrew Melville, Assist. Surgeon 79th Regt. Sept. 12th.—C. Judson Hill, Assist. Surgeon 91st Regt.; Frank C. Seelye, Assist. Surgeon 148th Regt., 2d Regt. 26th Dist. (new Regt.); George C. Hubbard, Assist. Surgeon 2d Batt. 5th Regt. (new); Cyrus Powers, Surgeon 3d Regt, 25th Dist. (new Regt.) Sept. 13th.—A. Walter Tryon, Assist. Surgeon 100th Regt.; Henry C. May, Assist. Surgeon 145th Regt. (new); Robert Rae, Assist. Surgeon 135th Regt. (new); Wm. Wood Squire, Assist. Surgeon 131st Regt. (new); Wm. Francis Cutland, Assist. Surgeon 132d Regt. (new). Sept. 16th.—John Quincy Adams, Surgeon 2d Regt., 8th Dist. (new Regt.) Sept. 17th.—Andrew J. Willets, Surgeon "Ironsides Regt." (new); John T. Brown, Assist. Surgeon 105th Regt.; John N. Miller, Assist. Surgeon 120th Regt., 10th Dist. (new Regt.) Sept. 18th.—D. Wellington Onderdonk, Assist. Surgeon 151st Regt., 29th Dist. (new Regt.); Jacob V. K. Schoeckel, Assist. Surgeon 103d Regt.; Thomas H. Stillwell Assist. Surgeon 23d Regt., vice William A. Madill promoted; Joseph T. Skinner, Assist. Surgeon 169th Regt., 2d Regt. 12th Dist. (new Regt.); Moses T. Babcock, Assist. Surgeon 141st Regt, 2d Regt. 27th Dist. (new Regt.) Sept. 19th.—Louis Kleine, Assist. Surgeon 3d Batt. of Artillery, vice Conrad Joachim deceased; Horace Nims, Assist. Surgeon 149th Regt., 2d Regt. 22d Dist., new Regt.)

WAR DEPARTMENT, ADJUTANT-GENERAL'S OFFICE,
WASHINGTON, October 11, 1862.

SPECIAL ORDERS, No. 289.

2. The following assignments are made of Medical Officers:—

Surgeon A. K. Smith, U.S.A., to relieve Surgeon George E. Cooper, U.S.A., as Medical Purveyor in Philadelphia, the latter, on being relieved, to proceed to the Head Quarters of General Buell's Army, and relieve Surgeon Robert Murray, U.S.A., as Medical Director of that Army.

Surgeon Robert Murray, on being relieved, will repair to Philadelphia and report to Surgeon W. S. King, as Medical Director of Transportation.

Assist. Surgeon B. A. Clements, U.S.A., will report to the Medical Board in Philadelphia for examination for promotion.

Surgeon Ira Russell, U. S. Vols., will report in person to the Assist. Surgeon-General in St. Louis, for orders.

* * * *

16. Surgeon Wm. P. Russell, 15th Vermont Vols., is hereby discharged the service of the United States.

* * * *

18. The following assignments are made of Medical Officers:—

Surgeon Paul B. Goddard, U. S. Vols., to report in person to Surgeon W. S. King, U.S.A., Medical Director at Philadelphia, Pa.

Surgeon D. H. Agnew, U. S. Vols., to report in person to Surgeon W. S. King, U.S.A., Medical Director at Philadelphia, Pa.

Surgeon A. B. Crosby, U. S. Vols., to report in person at General McClellan's Head Quarters.

Surgeon J. Hopkinson, U. S. Vols., to report in person to Surgeon W. S. King, U.S.A., Medical Director at Philadelphia, Pa., to take charge of Chestnut Hill Hospital.

Surgeon Clayton A. Cowgill, U. S. Vols., to repair to Newbern, N. C., and relieve Surgeon G. Derby, 23d Mass.

Vols., in charge of the Academy General Hospital in that city. Surgeon DERBY, when relieved, will join his regiment.

Surgeon B. B. BREED, U. S. Vols., to repair to Newbern, N. C., and relieve Surgeon G. A. OTIS, 27th Mass. Vols., in his duties at that place. Surgeon OTIS, when relieved, will join his regiment.

Surgeon S. D. FREEMAN, U. S. Vols., to report in person to Surgeon SIMPSON, U.S.A., Medical Director at Baltimore, Md., to relieve Surgeon R. W. PEASE, 10th New York Cavalry, in charge of General Hospital, Patterson Park.

Surgeon Israel Moses, U. S. Vols., to report to the Medical Director at Washington, D.C., for duty in Harewood Hospital.

Assist. Surgeon S. S. MULFORD, U. S. Vols., to proceed to Point Lookout, Md., and report to Assist. Surgeon CLINTON WAGNER, U.S.A., in charge.

Assist. Surgeon F. A. KEFFER, U. S. Vols., to report in person to Surgeon W. S. KING, U.S.A., Medical Director, for duty in West Philadelphia Hospital.

Assist. Surgeon A. MAJER, U. S. Vols., to report in person to Maj. Gen. MITCHELL, at Hilton Head, S. C.

Assist. Surgeon G. A. WHEELER, U. S. Vols., to report in person to Surgeon T. A. MCPARLIN, U.S.A., at General Hospital, Annapolis, Md.

Assist. Surgeon W. Moss, U. S. Vols., to report to Surgeon LETTERMAN, Medical Director Army of the Potomac, for special duty.

Assist. Surgeon J. H. BREWER, U. S. Vols., to report in person to Surgeon T. A. MCPARLIN, U.S.A., at General Hospital, Annapolis, Md.

Assist. Surgeon G. L. SUTTON, U. S. Vols., to report to the Medical Director at Washington, D.C., for duty in the Douglas Hospital.

Assist. Surgeon P. CLEARY, U. S. Vols., to report to the Medical Director at Washington, D.C., for duty in the Carver Hospital.

Assist. Surgeon A. H. SHELDON, U. S. Vols., to report to the Medical Director at Washington, D. C., for duty in his office.

Assist. Surgeon G. E. PATTEE, U. S. Vols., to report to the Medical Director at Washington, D.C., for duty.

Assist. Surgeon W. A. CONOVER, U. S. Vols., to report to the Medical Director at Washington, D.C., for duty in the Armory Hospital.

Assist. Surgeon C. S. FRINK, U. S. Vols., to report to the Medical Director at Washington, D.C., for duty in the Carver Hospital.

Surgeons HENRY J. CHURCHMAN, BARTON DARRACH, H. A. MARTIN, and J. R. MCCLURG, and Assist. Surgeons A. C. VAN DUZEN, S. B. DAVIS, and E. DODD, U. S. Vols., to proceed to St. Louis, Mo., and report to Assist. Surgeon-General R. C. WOOD, for duty.

By order of the Secretary of War.

E. D. TOWNSEND,
Assist. Adjutant-General.

Assist. Surgeon A. F. MECHEM, U.S.A., has been assigned to duty at Benicia Barracks, California.

Surgeon W. J. SLOAN, U.S.A., lately Medical Director in New York, has arrived at St. Paul, Min., and entered upon the duties of Medical Director of the Department commanded by Major Gen. POPE.

Surgeon BASIL NORRIS, U.S.A., is en route from Fort Craig, N. M., to Washington, D.C., under orders to report to the Surgeon-General.

Assist. Surgeon R. K. TUTHILL, 20th New York Vols., has been granted thirty days' leave of absence on Surgeon's certificate of disability.

During the absence of Assist. Surgeon C. T. ALEXANDER, at Philadelphia, Pa., to which city he has been ordered for examination for promotion, Assist. Surgeon SCHENCK has been detailed to act as member of the Army Medical Board at St. Louis.

Assist. Surgeon T. W. WILLIAMS, U.S.A., has been placed on duty in charge of the Trinity Church Hospital, Washington, D.C.

Assist. Surgeon B. HOWARD, U.S.A., is on duty as Medical Purveyor at Sharpsburg, Md.

Medical Storekeeper R. T. CREAMER, U.S.A., has arrived at St. Louis, and entered upon his duties in the Purveying Department.

Leave of absence for twenty days has been granted to Dr. A. H. HAVEN, Act. Assist. Surgeon, U.S.A.

Surgeon M. GOLDSMITH, U. S. Vols., has been assigned to duty as Assist. Medical Director at Louisville, Ky.

Surgeon GEORGE HAMMOND, U.S.A., recently returned from a six years' tour of duty in the Pacific Department.

Dr. NATHAN WEBB, Act. Assist. Surgeon U.S.A., has been directed by the Surgeon-General to report for duty to Surgeon J. J. MILHAU, at Frederick, Md.

Surgeon T. F. GALLOUPE, 13th Mass. Vols., has been placed on temporary duty in the city of Washington, while awaiting examination for appointment in the corps of Volunteer Surgeons.

Assist. Surgeon WM. C. FOSTER, 13th Indiana Vols., has been dismissed from the service of the United States.

Surgeon JOHN E. SUMMERS, U.S.A., is on leave of absence at Altoona, Pa.

Assist. Surgeon C. K. WINNE, U.S.A., has arrived at Evansville, Indiana, and assumed charge of the hospitals there.

Surgeon THOMAS ANTISELL, U. S. Vols., has been placed in charge of the Harewood Hospital at Washington.

Surgeon W. W. NASSAN, U. S. Vols., has been assigned to the hospital of the Sisters of Charity, St. Louis.

Surgeon DANIEL MEEKER, U.S.A., reports on duty with General MILROY'S brigade, Point Pleasant, Va.

Surgeon BERNARD VON BAIST, U. S. Vols., has been assigned to the charge of the General Hospital at Locust Spring, near Keedysville, Md.

Surgeon GEORGE SUCKLEY, U. S. Vols., has been placed on duty in the office of the Medical Director of the Army of the Potomac.

Surgeon LEWIS A. EDWARDS, U.S.A., has returned to Portsmouth Grove, R. I., having been summoned to Washington some time since on business connected with the General Hospital under his charge.

Assist. Surgeon J. B. HOOD, 75th Ohio Vols., now on duty at Columbus, Ky., has been directed to join his regiment.

Surgeon STEWART and Assist. Surgeon BOUTILLIER of the 1st Minnesota Vols. are directed to be mustered out of service.

The resignation of Assist. Surgeon J. F. KENNEDY, U.S.A., has been accepted to take effect October 10, 1862.

Leave of absence for thirty days from Nov. 1st. has been granted to Assist. Surgeon MCKINNEY, 57th New York Vols.

Assist. Surgeon C. C. GRAY, U.S.A., has been detailed to establish and take charge of General Hospital, Wilmington, Del.

Assist. Surgeon W. T. OKIE, U.S.A., has been assigned to General Hospital, Chester, Pa.

Surgeon C. C. GORDON, 1st N. J. Vols., has been assigned to duty as Medical Director at Trenton, N. J.

A Medical Board for the examination of such Medical Officers as may be reported to be professionally incompetent, has, at the request of the Medical Director Letterman, been convened at the Headquarters of the Army of the Potomac. Surgeons G. Suckley and P. Pineo, U.S. Vols., and Asst.-Surgeon Wilson, U.S.A., compose the board.

Owing to the approach of cold weather, the Medical Director at New York has been authorized to transfer eight hundred sick from David's Island to Fort Schuyler. It is also contemplated to remove all the sick of the Army from Bellevue Hospital.

The Act of Congress approved May 20, 1862, creating the Corps of Medical Storekeepers, provides that they shall have the pay and emoluments of Military Storekeepers of

the Quartermaster's Department, and they are therefore entitled to the fuel and quarters of First Lieutenant of the Army in kind, and in kind only.

The Surgeon-General has instructed the Medical Directors at New York, Philadelphia, and Baltimore, to collect in one hospital in each city all mutilated soldiers needing artificial limbs, so that they may be measured and fitted with such as speedily as possible.

The building on the corner of Ninth and Tattnall Streets, Wilmington, Delaware, has been selected for a hospital. The Quartermaster-General has been requested to rent it, and to erect suitable sheds for kitchen, laundry, etc.

It is in contemplation to erect a new General Hospital at Evansville, Indiana, the plans for which have been submitted to the Quartermaster-General.

REGULATIONS FOR ADMISSION AND PROMOTION IN THE MEDICAL DEPARTMENT OF THE NAVY.

It is prescribed by law that no person shall be appointed in this branch of the service who has not been examined and found qualified by a board of Naval Surgeons, designated by the Secretary of the Navy.

A board of Naval Surgeons will be assembled annually, at such place as may be indicated by the Department, usually about the close of the lecture season of the colleges, for the examination and selection of candidates for admission into the Medical Corps of the Navy, as well as for the examination of Assistant Surgeons who may be candidates for promotion.

Application for permission to attend the examination for admission to the Medical Corps of the Navy must be addressed to the Secretary of the Navy, stating the age and residence of the applicant, and be accompanied by respectable testimonials of his possessing the moral and physical qualifications requisite for filling creditably the responsible position of a Medical Officer of the Navy.

The application of no one will be considered who is under twenty-one or over twenty-six years of age.

The permission will state the time and place of the meeting of the board.

The board rigidly scrutinizes the physical qualifications of each candidate, as well as his moral, mental, and professional fitness for the Naval Service; and reports favorably upon no case admitting of a reasonable doubt, as the health and the lives of the officers of the Navy are objects too important to be intrusted to ignorant or incompetent persons.

The board reports the relative merit of the candidates as shown by the examination; and appointments will be made in the Navy as vacancies may occur, in the order in which they may be reported by the board.

No qualified candidate will be held over for appointment beyond one year; if not appointed within that time, it will be necessary for a candidate to be re-examined, when he will take position with the class last examined.

Physical examination will precede the professional; no candidate not physically qualified for the active duties of the service will be examined professionally. The board will make a separate report in each case of the physical condition *direct* to the Department, to be placed on file with the testimonials of the candidate.

No allowance is made for the expenses of persons undergoing these examinations, as they are indispensable prerequisites to appointment.

After five years' service in the Navy, at least two years of which shall have been passed "on board a public vessel of the United States at sea," Assistant Surgeons shall be entitled to an examination for promotion.

In order that the relative position of Assistant-Surgeons of the same date, who shall be examined for promotion at different times, may be more readily determined, a majority of the members of the board will be selected, if practicable, from those who served on the next preceding board.

Assistant Surgeons, who are candidates for promotion, shall present to the board testimonials of correct deportment and habits of industry from the Surgeons with whom they have been associated on duty; also, a Journal of Practice, or Case Book, in their own hand-writing. They are expected to be familiar with all the details of duty specified in the "Instructions for the government of Medical Officers."

Any Assistant Surgeon who shall fail to present himself for examination after he has been ordered (unless for reasons which may be satisfactory to the Department), or who, after examination, shall be reported by the board as "not qualified" for promotion, shall be dropped from the list of Officers of the Navy.

GIDEON WELLES, *Secretary of the Navy.*

COMPENSATION.—The pay of Assistant Surgeons and Surgeons is established by act of Congress, approved on the 1st of June, 1860, and is as follows:

FLEET SURGEONS	$3,300 00
SURGEONS—	
On duty at sea—	
For first five years after date of commission as surgeon	2,200 00
For second five years after date of commission as surgeon	2,400 00
For third five years after date of commission as surgeon	2,600 00
For fourth five years after date of commission as surgeon	2,800 00
For twenty years and upwards after date of commission	3,000 00
On other duty—	
For first five years after date of commission as surgeon	2,000 00
For second five years after date of commission as surgeon	2,200 00
For third five years after date of commission as surgeon	2,400 00
For fourth five years after date of commission as surgeon	2,600 00
For twenty years and upwards after date of commission	2,800 00
On leave or waiting orders—	
For first five years after date of commission as surgeon	1,600 00
For second five years after date of commission as surgeon	1,800 00
For third five years after date of commission as surgeon	1,900 00
For fourth five years after date of commission as surgeon	2,100 00
For twenty years and upwards after date of commission	2,300 00
PASSED ASSISTANT SURGEONS—	
On duty at sea	1,500 00
On other duty	1,400 00
On leave or waiting orders	1,100 00
ASSISTANT SURGEONS—	
On duty at sea	1,250 00
On other duty	1,050 00
On leave or waiting orders	800 00

FORM OF APPLICATION.

, 186

To the Secretary of the Navy:

I respectfully make application for examination as to my qualifications for appointment as Assistant Surgeon in the United States Navy. I was years of age, on the day of , 186 , and reside in , county of and State of . I forward herewith testimonials of moral and physical qualifications.

Very respectfully,

POTHOUSE POISON.—A young man named Flasschoen very narrowly escaped being poisoned last week at Brussels from drinking the first glass of beer drawn from the counter machine at a public-house. It is usual to throw away the beer which has remained in the metal pipes all night, but this precaution had been neglected in the present instance. The liquor was so strongly impregnated with the metallic poison that the young man's recovery was considered hopeless for several hours.—*Dub. Med. Press.*

WHEN a patient is in a sinking state from disease, and when a medical man has thought an alcoholic stimulant absolutely necessary to snatch the patient from death, in this case the great danger is, that such a stimulant will extinguish the small spark of life remaining, and that the patient will be destroyed. It was truly said of the Brunonian system, "that Dr. Brown had made no provision in his system for the recovery of exhaustion arising from the effects of taking alcoholic stimulants." Lord Bacon observes: "If the spirit is assailed by another heat stronger than its own, it is dissipated and destroyed."—*Mr. Higginbottom, in Brit. Med. Jour.*

MARRIED.

WARNER—GREENMAN.—Sept. 23d, at the Congregational Church, Mc-Grawville, N. Y., by the Rev. E. B. Fancher, J. DEVER WARNER, M.D., of Nineveh, Broome Co., to Miss LUCETTA M. GREENMAN, of the former place.

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK.

Abstract of the Official Report.

From the 13th day of October to the 20th day of October, 1862.

Deaths.—Men, 82; women, 66; boys, 105; girls, 100; total, 353. Adults 148; children, 205; males, 187; females, 166; colored, 8. Infants under two years of age, 139. Children born of native parents, 11; foreign, 164.

Among the causes of death we notice:—Apoplexy, 4; infantile convulsions, 21; croup, 20; diphtheria, 7; scarlet fever, 7; typhus and typhoid fevers, 6; consumption, 58; small-pox, 2; measles, 0; dropsy of head, 11; infantile marasmus, 29; cholera infantum, 21; inflammation of brain, 6; of bowels, 7; of lungs, 20; bronchitis, 4; congestion of brain, 7; of lungs, 5; erysipelas, 1; diarrhœa and dysentery, 15. 179 deaths occurred from acute diseases, and 84 from violent causes. 248 were native, and 115 foreign; of whom 68 came from Ireland; 40 died in the City Charities; of whom 9 were in Bellevue Hospital, and 1 died in the Immigrant Institution.

Abstract of the Atmospherical Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

Oct. 1862	Barometer.		Temperature.			Difference of dry and wet bulb. Thrm.		Wind.	Mean amount of cloud.	Humidity. Sat'tion, 1000
	Mean height.	Daily range.	Mean	Min.	Max.	Mean	Max.			
	IN.	IN.	°	°	°	°	°			
12th:	30 00	.10	54	47	60	4	5	N. to S.	10	748
13th.	29.87	.21	50	45	53	5	7	N.E.	10	698
14th.	29.91	.10	54	47	61	7	11	N.W.	7	566
15th.	30.00	.10	55	48	61	9	15	N.	5	525
16th.	30.00	.10	50	46	56	5	4	N.E to S.E	9	698
17th.	30.00	.11	60	50	67	7	11	W.	2	600
18th.	30.17	.14	56	50	65	7	11	N. to S.	.04	590

REMARKS.—13th, N.E. storm A.M. 14th, Variable. 15th, Clear most of the day—fresh wind A.M., cloudy P.M., with a few drops of rain. 16th, Light rain at noon; clear, late at night. 17th, Variable A.M., clear P.M. 18th, Fine day. Half an inch of rain fell during the week.

SPECIAL NOTICES.

WARD'S ISLAND HOSPITAL.—DR. CARNOCHAN *will perform the operation of Amputation of the Thigh, to-day (Saturday, Oct. 25th), at 2 o'clock P.M.*

PROF. FRANK H. HAMILTON, M.D., late Med. Director of the Fourth Corps d'Armée, in charge Central Park Gen. Hospital, *will commence his Course of Lectures on Military Surgery, etc., at the Bellevue Hospital Medical College, on Saturday, Nov. 1, at 1 o'clock P.M. The Lectures will be continued on each succeeding Saturday at the same hour.*

AUSTIN FLINT, JR., Secretary.

American Journal of Ophthalmology

JULIUS HOMBERGER, M.D., EDITOR.

No. 2, for September, just published.

Subscription Price for one year (six numbers), $2.00; sample numbers free.

BAILLIERE BROTHERS,
440 Broadway, New York.

Diagrams of the Nerves of the

Human Body, exhibiting their Origin, Divisions, and Connexions, with their Distribution to the Various Regions of the Cutaneous Surface and to all the Muscles, by W. H. Flower, M.D. Folio. London, 1861. $5.60.

BAILLIERE BROTHERS, 440 Broadway, N. Y.

New England Mutual Life Ins. Co.,

BOSTON AND NEW YORK, ORGANIZED 1843. **ASSETS, $2,350,000.** Documents showing the benefits of Life Insurance with the advantages of the Mutual plan, and the superior position and marked success of this Co., and explaining the different kinds of Policies with their methods of payment, may be obtained free of expense, upon application, either personally or by mail, to JOHN HOPPER, Agent and Attorney for the Co., Metropolitan Bank Building, 110 Broadway, New York. ☞ *Parties at a distance may insure from Blanks, which will be forwarded free of expense.*

New York Eye Infirmary,

2D AVENUE AND 13TH STREET.

LECTURES for the coming winter will begin on WEDNESDAY, OCTOBER 22d. The Course will be made a complete resumé of

OPHTHALMIC MEDICINE AND SURGERY.

Lectures will be held on

MONDAY, WEDNESDAY, AND FRIDAY,

BY DRS. C. R. AGNEW, AND HENRY D. NOYES.

The means of illustration by colored plates, optical apparatus, and morbid specimens, are ample.

The surgeons have concluded to issue a diploma to those who attend the Lectures and can pass a satisfactory examination.

Fee for Lectures, ... $10.00
Diploma Fee, ... 5.00

DEMONSTRATIONS OF THE

INTERNAL DISEASES OF THE EYE,

WITH THE OPHTHALMOSCOPE,

will be made during the Lectures, while a more complete acquaintance with these diseases can be had in a private class with Dr. Noyes.

THE CLINIQUES OF THE INFIRMARY,

ON MONDAY, WEDNESDAY, AND FRIDAY,

are free to all medical men and students. More than 5,000 patients are treated annually.

Dr. Churchill's Hypophosphites.

PREVENTION AND CURE OF CONSUMPTION

A supply of these important medicines,

SYRUP OF HYPOPHOSPHITE OF SODA,
SYRUP OF HYPOPHOSPHITE OF LIME,
PILLS OF HYPOPHOSPHITE OF QUININE,
PILLS OF HYPOPHOSPHITE OF MANGANESE,

has arrived from Paris with directions for use. Persons suffering from chest affections can now procure the above preparations genuine, as used by Dr. Churchill from the following agents in America.

Messrs. Hegeman & Co., Broadway, New York, Mr. F. Brown, corner of Fifth and Chestnut Streets, Philadelphia; Messrs. T. Metcalfe & Co., Boston; Messrs. J. T. Brown & Sons, 425 Washington Street, Boston.

Wholesale orders to be addressed to H. H. SWANN, Pharmacien, 12 rue Castiglione, Paris.

To the Medical Profession.—Dr. I.

Parigot has changed his residence and is prepared to receive a very limited number of patients in his country house at Hastings, on the Hudson; he can be consulted in town at Dr. Douglas' Office, No. 12 Clinton Place, on Tuesdays and Saturdays, for Nervous Diseases and Medico-Legal questions.

Records of Daily Practice: a Scientific

VISITING LIST FOR PHYSICIANS AND SURGEONS.

CONTENTS:

Present State of Patients	72 double pages.
Microscopical Examinations	4 pages.
Obstetrical Engagements	4 "
Vaccination "	4 "
Consultation and other Professional Engagements	4 "
List of Nurses and Address	2 "
Meteorological Observations and Endemic Influences	4 "
Miscellaneous Memoranda	6 "
Index of Patients	4 "

This little book is not intended to supersede the use of a regular visiting list; its aim, as the title indicates, is to supply a medium for taking notes of the state of the patient, as soon after the visit as it is possible, and whilst the facts are still fresh in the memory. In hospital practice we believe it will be found invaluable. The arrangement, under the head of "*Present State of the Patient*," is admitted, by competent judges, to be all that could be desired.

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